Exhibit 3

UNITED STATES DISTRICT COURT
MIDDLE DISTRICT OF NORTH CAROLINA

PLANNED PARENTHOOD SOUTH ATLANTIC and BEVERLY GRAY, MD, Plaintiff, v. JOSHUA STEIN, TODD M. WILLIAMS, JIM O'NEILL, SPENCER MERRIWEATHER, AVERY CRUMP, JEFF NIEMAN, SATANA DEBERRY, WILLIAM WEST, LORRIN FREEMAN, BENJAMIN R. DAVID, KODY H. KINSLEY, MICHAUX R. KILPATRICK, MD, PHD, and RACQUEL INGRAM, PHD, RN, all in their official capacities Defendants. and PHILIP E. BERGER and TIMOTHY K. MOORE Intervenor-Defendants.	**Case No. 1:23-cv-480**

DECLARATION OF SUSAN BANE, M.D., Ph.D.

I, Susan Bane, MD, PhD, pursuant to the provision of 28 U.S.C. § 1746, do herby declare as follows:

1. I am at least 18 years of age and competent to testify. I have personal and professional knowledge of the statements contained in this declaration. The opinions I express in this declaration are based on my education, training, familiarity with the medical literature, and expertise as an obstetrician/gynecologist who sees

patients with unplanned pregnancies in Eastern North Carolina. These opinions are my own, and do not represent any group with which I am affiliated.

I. Introduction and Professional Background

2. I am a board-certified Obstetrician and Gynecologist. I completed my undergraduate degree at Atlantic Christian College, now Barton College, and majored in Chemistry. I attended the University of Illinois, completing both my Medical Degree (MD) and Doctorate (PhD) in Kinesiology. I completed my Obstetrics and Gynecology residency at Pitt Memorial Hospital, now ECU Health, which is affiliated with the Brody School of Medicine at East Carolina University in Greenville, North Carolina.

3. I have practiced obstetrics and gynecology for over 20 years in Eastern North Carolina since completing my residency. I was in private practice at Greenville Obstetrics and Gynecology for nine years. During that time, I provided obstetrical, gynecological, primary, and hospital-based care at Pitt Memorial Hospital, now ECU Health, in Greenville, North Carolina. I served as a community clinical preceptor in the outpatient and inpatient settings, teaching both medical students and resident physicians. I also lectured at the Brody School of Medicine on topics related to labor and delivery and was the primary instructor for a fourth-year medical elective titled "Residency 101."

4. During my time in private practice, I helped women deliver over 1000 babies and supervised midwives who helped women deliver several thousand babies. My obstetric practice was comprehensive, including, but not limited to vaginal

deliveries, vacuum-assisted vaginal deliveries, cesarean sections, care for women with medical emergencies, including ectopic pregnancies, care for women and pre-born children with life limiting conditions, care of women with miscarriages/fetal demise, prenatal care, and post-partum care. My gynecological practice was also comprehensive, including, but not limited to gynecological surgery, preventive and primary care.

5. I was sidelined in 2010 from delivering babies due to a shoulder injury and became a faculty member at Barton College in Wilson, NC, working there from 2011 to 2023. I was a tenured associate professor of Allied Health and Sport Studies. My teaching responsibilities included a wide variety of courses including, but not limited to anatomy and physiology, exercise physiology, allied health and sport studies, contemporary issues in medicine and health, nature of inquiry, health behavior theory, and health program planning, implementation, and evaluation.

6. My administrative responsibilities during my time at Barton College included serving as the Director of the Whitehurst Family Honors Program, Dean of the Graduate and Professional Studies Program, and Director of the Barton College-Area L AHEC Partnership.

7. I wrote and/or implemented grants to address community and campus health and well-being, as well as health careers diversity and workforce development. These included local, state, and federal grants. Funding was received from The Healthcare Foundation of Wilson, Health Resource Service Association (HRSA), Interfaith America, and North Carolina Department of Health and Human Services

(NC DHHS). Programming brought to campus through this work included health and wellness lectures, exercise programs/classes, farmer's market, health fair, mental health first aid, and a lecture series on the role of spirituality in medicine. I led the development of clinical virtual modules for students displaced from clinical experiences during COVID focusing on the value of the interprofessional health care team, health disparities, social determinants of health, cultural competency, the opioid crisis, aging, chronic disease, adverse childhood experiences, and pandemics. Currently, I am consulting through the Area L AHEC - Barton College partnership on an initiative for the College to become a trauma-informed campus.

8. I continued practicing medicine while a faculty member at Barton College, working in the student health center seeing patients, and then serving as a consultant to the student health center and the athletic department/athletic trainers during my time at Barton College. I care about patient health and healing deeply and examining the root causes of dysfunction and disease. These interests in health care led me to complete certifications in functional medicine, health coaching, emotional intelligence coaching, and theology, medicine, and culture while working at Barton College.

9. I have served as the medical director of Choices Women's Center for several years and in the past year became the medical director of two other pregnancy centers in rural Eastern North Carolina. I oversee all clinical aspects of the medical clinics and see patients with unintended pregnancies. I am in the trenches with women with unplanned pregnancies as they face a decision of massive consequence –

to give birth and parent, to give birth and decide about where to place their child (adoption), or give permission for a health care provider to end the life of their pre-born child.

10. My patients are often scared, alone, and coerced. They often face barriers when they experience an unplanned pregnancy. What we hear from women at our Centers is consistent with what the literature states are the most common reasons women choose to have induced abortions - socioeconomic factors such as interference with education or work, financial constraints, lack of support from the father of the baby, or poor timing (not ready to be a mother or finished having children).[1]

11. The specific reasons women choose to have an induced abortion are as multiple and diverse as the women who experience them. Day in and day out, I see women who are trapped in the cruel predicament in contemporary America in which they see giving permission to end the life of their very own pre-born children as their only option. Women with an unintended pregnancy have a massive decision in front of them that is often shrouded in secrecy and has the potential to haunt them for years to come. They need a place to go where they can receive exceptional medical care, are empowered with information, and gain confidence to face the barriers in front of them. That is exactly what we do at the three pregnancy centers for which I serve as the Medical Director.

[1] Chae, S., Desai, S., Crowell, M., & Sedgh, G. (2017). Reasons Why Women Have Induced Abortions: A Synthesis of Findings from 14 Countries. *Contraception (96):* 233-241. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5957082/.

II. Expert Opinions

A. Maternal Mortality and Induced Abortion in North Carolina

i) Abortion Is Common, Not Safe, and Not Essential Health Care.

12. The plaintiffs' witnesses claim that abortion is common, safe, and essential health care. Induced abortions are common. Approximately 1 in 4 women in America have had an induced abortion, with estimates from the CDC and Guttmacher Institute of 43,000,000 – 63,000,000 induced abortions since the landmark *Roe v. Wade* Supreme Court decision in 1973 that legalized abortion in our country.[2] Because abortion is common does not mean it is necessarily safe or essential. To unpackage the plaintiffs' claim that abortion is safe and essential health care, we must first define abortion and then examine both maternal mortality and abortion data in North Carolina.

ii) Abortion defined.

13. The term "abortion" in medical language represents any pregnancy that ends prior to 20 weeks gestation. It is an umbrella term used to describe various types of abortions in the clinical setting. For example, if a woman is cramping or bleeding, but everything looks normal on physical exam and ultrasound, she would likely be diagnosed with a "threatened abortion" or a pregnancy that is at risk of not surviving. A "spontaneous abortion" is a miscarriage that a woman passes on her own or naturally. This patient will often experience bleeding and/or cramping and may even see the embryo or fetus. A "missed abortion" occurs when a woman is asymptomatic,

[2] https://nrlc.org/uploads/factsheets/FS01AbortionintheUS.pdf.

and we are unable to find a heartbeat. With a missed abortion, the woman has yet to start bleeding or cramping and not passed the embryo or fetus. If a woman is in the process of miscarrying, the term "incomplete abortion" is used, as the miscarriage is not finished. The term "complete abortion" is used when a woman has already completed the miscarriage process (typically cramping and bleeding have already happened).

14. These types of abortion described above are completely different from an induced abortion which is at the center of this law. The CDC defines induced abortion as "an intervention performed by a licensed clinician (e.g., a physician, nurse-midwife, nurse practitioner, physician assistant) within the limits of state regulations, that is intended to terminate a suspected or known ongoing intrauterine pregnancy and that does not result in a live birth."[3]

iii) Maternal Mortality in North Carolina.

15. Obstetricians and gynecologists care for two patients – a maternal and fetal patient. Our profession of doctoring is one that is bound by an oath to heal – to work towards health and wholeness for both our patients. The Hippocratic Oath requires physicians to "first, do no harm." North Carolina cares about women and wants no woman "to die as a result of pregnancy" as stated in our state's 2021 Maternal Mortality Review Report that provides a comprehensive summary of

[3] https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.

maternal mortality statistics and strategies for reducing maternal mortality – for reducing harm and providing safety for our maternal patients.[4]

16. Pregnancy-associated death is the death of a woman while pregnant or within one year of the termination of pregnancy, regardless of the cause. These deaths are pregnancy-related deaths and pregnancy-associated, but not related deaths.

17. Historically, gathering accurate maternal mortality data at both the state and national level has been fraught with errors, leading to the inability to draw meaningful conclusions.[5] One national approach that was taken to improve data collection included the requirement to add a pregnancy checkbox to death certificates in 2003. The pregnancy checkbox was finally added to the North Carolina death certificate beginning in 2014 and all maternal mortalities identified through the pregnancy checkbox alone are then confirmed for accuracy. North Carolina links death and birth certificates to allow improved tracking of maternal deaths. Thus, if a woman who has had a live birth in the last year commits suicides the following year, we have a way to link those two events. Most importantly, North Carolina passed legislation in 2015 that led to the formation of a Maternal Mortality Review Committee (MMRC) to review pregnancy-associated deaths, make recommendations for prevention, and disseminate findings.

[4] https://wicws.dph.ncdhhs.gov/docs/2014-16-MMRCReport_web.pdf.
[5] MacDorman, M.F., Declercq, E. Cabral, H, and Morton, C. (2016). Recent Increases in the U.S. Maternal Mortality Rate: Disentangling Trends From Measurement Issues. Obstetrics Gynecology 128(3): 447-455.

18. As this report demonstrates, North Carolina has made advances in reducing maternal mortality for all women, but disparities clearly still exist. Key findings for 2014-2016 data reported in this 2021 report revealed that a total of 228 deaths occurred and 60 of those were pregnancy-related deaths.

19. Among the 60 pregnancy-related deaths, the most common causes of death included hemorrhage, pulmonary embolism (blood clot to the lungs), infections, cardiomyopathy, preeclampsia, eclampsia, cardiovascular and coronary disease, cerebrovascular accidents, mental health conditions, and homicide. After a thorough review of deaths from 2014 to 2016, the MMRC determined that more than two-thirds (70%) of North Carolina pregnancy-related deaths were preventable. [6]

20. Demographic factors that impacted the 60 pregnancy-related deaths included:

- Education: among the 60 pregnancy-related deaths, over half (65%) occurred to those with a high school education or less.
- Race/Ethnicity: 85% of all pregnancy-related deaths occurred among non-Hispanic white and non-Hispanic Black women.
- Urban/Rural: both rural and urban areas of the state accounted for similar proportions of all pregnancy-related deaths (37% and 40%, respectively). Regional cities/suburban areas comprised 23% of all deaths.

21. Recommendations and strategies aimed at preventing pregnancy-related deaths in North Carolina were given by the MMRC committee. Categories for classifying committee recommendations by contributing factors included:

[6] https://wicws.dph.ncdhhs.gov/docs/2014-16-MMRCReport_web.pdf.

- Provider recommendations focusing on the education and training of providers on adherence to clinical guidelines and protocols, as well as proper patient screening and follow-up.

- Patient/Family recommendations focusing on the need for patient education before, during, and after pregnancy on essential health-related topics.

- System recommendations focusing on a variety of approaches from a systems level, including developing consistent guidelines across the state that would provide education on early warning signs and integrate early warning tools that create an appropriate rapid response to detect rapid deterioration.

- Facility recommendations focused primarily on policies and procedures that address patient safety.

- Community recommendations including provision of community education and awareness on various health-related topics.

22. Greater access to induced abortion as a safe and essential healthcare strategy for addressing maternal mortality is not found in this report. Rather, this report focuses on the transformative strategies that address root causes and barriers women face when pregnant with a goal to restore women's health with a non-violent and caring approach.

23. The Plaintiffs falsely claim that this law will harm women and is "an attack on families with low incomes, North Carolinians of color, and rural North Carolinians, who already face inequities in access to medical care and who will bear the brunt of the Act's cruelties."[7]

24. Understanding racial disparity in pregnancy-related mortality is imperative both in our state and country. The plaintiffs falsely claim that this law

[7] Farris Decl. ¶ 10.

that regulates induced abortion has a disparate negative impact on minority women. This argument serves to further target minorities by creating even higher rates of induced abortion which could lead to greater rates of maternal mortality – something that is already unacceptably high in North Carolina and the United States. There are significant differences in birth outcomes in black women in the United States when compared with non-Hispanic white women. The rates of natural losses are similar (16%), but 34% of pregnancies in black women end in induced abortion, compared to 11% for white women.[8] Less than half of pregnancies in black women result in the birth of a live baby (48%). Induced abortion is 3-4 times more common in black than in non-Hispanic white women, and black women more commonly have later abortions (13%) compared with white women (9%).

25. CDC researchers found that the risk of death from induced abortion increased by 38% for each additional week of gestation. Compared with women whose abortions were performed at or before 8 weeks of gestation, women whose abortions were performed in the second trimester were significantly more likely to die of abortion-related causes.[9] If black women already have 3-4 times higher induced abortion rates and higher maternal mortality rates, then access to more induced abortions is not the solution to reduce maternal mortality. It is possible that the higher rate of induced abortion and later abortions in black women account for a

[8] Jones, RK and Finer, LB. (2012). Who Has Second Trimester Abortions in the United States? Contraception. 85(6):544-551.
[9] Bartlett, L, Berg, C, Shulman, H, Zane, S, Green, C, Whitehead, S, & Atrash, H. (2004). Risk Factors for Legal Induced Abortion-Related Mortality in the United States. Obstetrics and Gynecology. 103(4):727-737.

portion of the racial disparity noted in pregnancy mortality and this law will actually be protective for black women.

26. The most recent data from the CDC on maternal mortality released in 2023 present a harsh reminder that our nation's women desperately continue to need better access to high-quality healthcare. 2021 saw a 40% rise in maternal deaths and the highest numbers since 1965. [10] The U.S.'s poor maternal health is shameful.

27. The causes of our maternal mortality numbers are multi-factorial and include deeply rooted socioeconomic inequalities. However, most causes are preventable and not improved by increasing access to induced abortion. [11]

28. North Carolina's MMRC report aligns with these recent U.S. maternal mortality data and directly contradicts the claims by plaintiffs that the law targets these vulnerable populations. Eighty-five percent of the pregnancy-related deaths in North Carolina occurred in women who were non-Hispanic white and non-Hispanic Black women and over half (65%) occurred to those with a high school education or less (correlated with lower income). Both rural and urban areas of the state had similar proportions of all pregnancy-related deaths. If induced abortion was essential health care for these vulnerable populations as the plaintiffs' claim, this report would have highlighted this need. It does not. Rather, North Carolina's 2021 MMRC document focuses on essential health care solutions that make North Carolinian women who are pregnant safer, just as documents cited above from the CDC do. The

[10] https://www.cdc.gov/reproductivehealth/data_stats/abortion.htm.
[11] Peterson, E. et al. (2019). Racial/Ethnic Disparities in Pregnancy-Related Deaths- United States MMWR Morbidity and Mortality Weekly Report 68(35): 762-765.

state of North Carolina recognizes that women need health care solutions that focus on root causes of maternal mortality, from a system level to an individual level. They address maternal mortality without including induced abortion because induced abortion is not essential health care.

iv) Abortion Data in North Carolina

30. Unlike maternal mortality, there is no mandatory requirement to report numbers of abortion or complications of abortions nationally or in individual states. Reporting to the CDC at the state level is also voluntary. The North Carolina Department of Health and Human Services (NCDHHS) provides vital statistics for reported pregnancies. North Carolina's 2021 abortion statistics were published online by the NCDHHS in May 2023.[12] The report states that the total pregnancies represent the sum of all induced abortions, live births, and fetal deaths 20 or more weeks of gestation reported in the state. Spontaneous fetal deaths (still births) occurring prior to 20 weeks gestation are not reportable to the state. Unlike maternal mortality data in North Carolina in which death and birth certificates are linked, death certificates and induced abortion data are not linked and thus we have incomplete data related to induced abortion.

31. Data provided from this North Carolina report, as well as national reports, are underestimations of both numbers of abortions and complications from abortions.[13] In 2021, there were 32,454 abortions reported in North Carolina, an

[12] https://schs.dph.ncdhhs.gov/data/vital/pregnancies/2021/.
[13] Studnicki, J. et al. (2017). Improving Maternal Mortality: Comprehensive Reporting for All Pregnancy Outcomes. Open Journal of Preventive Medicine; 7:162-181.

increase of 8.2 percent from 2020. Chemical abortions increased by 21 percent from 2020 and represented 66 percent of resident abortions. Non-Hispanic black women composed the largest group of North Carolina residents undergoing abortions, making up 49 percent of the total even though non-Hispanic black women make up just 24 percent of North Carolina's overall population of women of childbearing age. Twenty-seven percent of the abortions were on non-Hispanic white women. Based on reported induced abortions, there is a large difference between the abortion rates of non-Hispanic black and white women of childbearing age in North Carolina. The black abortion rate in North Carolina in 2021 was 27.3, four times higher than the white abortion rate of 6.3.

32. Reporting of the number of induced abortions and complications will be mandatory with this law and thus allow more accurate understanding of the number of women in North Carolina who have induced abortion, as well as the risks of those abortions. Until then, we must look outside the state to other sources of more accurate data collection.

33. When looking at countries where comprehensive and transparent data collection is performed, a much clearer picture of the impact of induced abortion is presented. According to a 2016 study conducted in Finland, after termination of pregnancy by induced abortion, the mortality rate for external causes was 8.1/100,000 after pregnancies ending with delivery, whereas after termination of pregnancy, the mortality was sixfold higher (49.5/100,000). Importantly, for all pregnancy outcomes, in all age groups under 40, mortality rates were highest after termination of

pregnancy.[14] A study of maternal mortality data from 32 states in Mexico by Koch, et al, revealed that laws that restrict abortion do not lead to an increase in maternal mortality - a claim that is made by plaintiffs. Koch's study showed that states with less permissive abortion legislation exhibited lower maternal mortality ratios (MMR) overall (38.3 vs 49.6), MMR with any abortive outcome (2.7 vs 3.7) and induced abortion.[15] Additionally, geographically diverse countries which prohibit abortion after previously allowing it have not seen their maternal mortality worsen, rather it has improved. This is compared to South Africa which has seen maternal mortality worsen after the legalization of abortion.[16]

34. There are two primary types of induced abortions: chemical abortions and surgical abortions. Chemical abortions typically consist of a two-drug regimen. Mifepristone is taken first, followed by misoprostol 24-48 hours later. Mifepristone leads to death of the embryo/fetus and misoprostol causes uterine contractions which leads to expelling the embryo/fetus. This regimen is approved by the FDA through 70 days or 10 weeks gestation. Surgical abortions involve the mechanical dilation of the cervix followed by vacuum aspiration or removal of the fetus by dismemberment, depending on the gestational age of the embryo/fetus.

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[14] Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012. BJOG:An International Journal of Obstetrics & Gynaecology, 124(7), 1115-1121.

[15] Koch E, Chireau M, Pliego F,et al. Abortion legislation, maternal healthcare, fertility, female literacy, sanitation, violence against women and maternal deaths: a natural experiment in 32 Mexican states. BMJ Open2015;5:e006013. doi:10.1136/bmjopen-2014-006013.

[16] Hogan MC, Foreman KJ, Naghavi M,et al. Maternal mortality for 181 countries, 1980–2008: a systematic analysis of progress towardsMillennium Development Goal 5. Lancet 2010; 375: 1609–23.

35. Induced abortion is associated with several documented short- and long-term risks. The 2022 Clinical Guidelines from the National Abortion Federation (a professional association of abortion providers) state that the minimum risks that must be addressed for all abortion procedures include hemorrhage, infection, uterine perforation, damage to organs including hysterectomy, continued pregnancy, and death.[17] Complications can occur with both chemical and surgical induced abortion, though rigorous registry-based studies show that chemical abortions have a 4x higher risk of complications compared to surgical abortions. [18] Risk of complications for both chemical and surgical abortions are proportional to gestational age. At 10 weeks gestation, the current upper limit approved by FDA for a chemical induced abortion, 1 in 10 women will require a surgery to complete their abortion. This increases to 1 in 2-3 women at 13 weeks gestation.[19] Because uterine perforation and damage to organs can occur in surgical abortions, this adds an additional layer of risk for women who have a complication from a chemical abortion and subsequently need a surgical abortion.

36. Long term complications include risk for pre-term birth (PTB) and mental health issues.

v) Pre-term birth

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[17] National Abortion Federation. 2022 Clinical Policy Guidelines for Abortion Care. https://prochoice.org/wp-content/uploads/2022-CPGs.pdf. Accessed 12/17/2022.

[18] Niinimäki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate complications after medical compared with surgical termination of pregnancy. Obstet Gynecol. 2009 Oct;114(4):795-804. doi: 10.1097/AOG.0b013e3181b5ccf9. PMID: 19888037.

[19] Mentula MJ, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study. Hum Reprod. 2011 Apr;26(4):927-32. doi: 10.1093/humrep/der016. Epub 2011Feb 11. PMID: 21317416.28 https://www.accessdata.fd.

37. The Institute of Medicine (now the National Academy of Medicine) has listed induced abortion as an immutable risk factor for preterm birth (PTB).[20] A single induced abortion increases the risk. Hanes et al., determined that a single prior abortion increased the risk of a future very preterm birth by 64 percent.[21] More than one abortion has been show to increase the risk for preterm birth by 93 percent.[22]

38. This increased risk of preterm birth is especially impactful in the black population that has a 2x higher PTB rate and a 3-4x higher induced abortion rate.[23] Non-hispanic black race (compared with non-hispanic white race) is a consistent risk factor for preterm birth and adverse pregnancy outcomes in the United States. In a large systematic review of 30 studies, black women were found to have a 2-fold increased risk compared with whites.[24]

vi) Mental Health

39. In addition to the physical ramifications of induced abortion, there is also a relationship between induced abortions and mental health complications, including depression, suicide, substance use disorder, and suicide. Mota et al. in 2010 discovered that abortion was associated with an increased likelihood of several

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[20] Institute of Medicine. Preterm Birth: Causes, Consequences, and Prevention Committee on Understanding Premature Birth and Assuring Healthy Outcomes; Behrman RE, Butler AS, editors. Washington (DC): National Academies Press (US); 2007.

[21] Hanes M. Swingle, Tarah T. Colaizy, M. Bridget Zimmerman & Frank H. Morris, Jr. Abortion and the Risk of Subsequent Preterm Birth: A Systematic Review with Meta-analyses. J. REPRODUCTIVE MED. 95-108 (2009)14.

[22] Shah PS, Zao J; Knowledge Synthesis Group of Determinants of preterm/LBW births. Induced termination of pregnancy and low birth weight and preterm birth: a systematic review and meta-analysis. BJOG 2009;116(11):1425-1442.

[23] Behrman, R.E. & Butler, A.S. (Eds.). (2007). Preterm birth: causes, consequences, and prevention. National Academies Press.

[24] Schaaf JM, Liem SM, Mol BW, Abu-Hanna A, Ravelli AC. Ethnic and racial disparities in the risk of preterm birth: a systematic review and meta-analysis. Am J Perinatol. 2013 Jun; 30(6):433-50.

mental disorders, mood disorders, anxiety disorders, substance use disorders, as well as suicidal ideation and suicide attempts.[25] Fergusson et al. in 2008 found that women who had abortions had 30% increased rates of mental disorders, [26] Coleman used data from the National Longitudinal Study of Adolescent Health, and found that adolescents who aborted an unwanted pregnancy were more likely than adolescents who delivered to seek psychological counseling and they reported more frequent problems sleeping and more frequent marijuana use.[27]

40. A Finnish study on maternal mortality showed an alarming 7x higher suicide rate after abortion when compared to giving birth. The mortality rate for suicides was 3.3/100,000 in ongoing pregnancies and pregnancies ending in birth while it was 21.8/100,000 after termination of pregnancy and 10.2/100,000 among non-pregnant women, showing a protective effect from giving birth.[28]

41. It is rational for the State of North Carolina to regulate induced abortions for interventions with such potentially catastrophic risks.

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[25] Mota, N.P., Burnett, M., & Sareen, J. (2010). Associations between abortion, mental disorders, and suicidal behavior in a nationally representative sample. The Canadian Journal of Psychiatry, 55 (4), 239-247.

[26] Fergusson, D.M., Horwood, L. J., & Boden, J. M. (2008). Abortion and mental health disorders: evidence from a 30-year longitudinal study. The British Journal of Psychiatry, 193, 444-451.

[27] Coleman, P. K. (2006). Resolution of unwanted pregnancy during adolescence through abortion versus childbirth: Individual and family predictors and psychological consequences. The Journal of Youth and Adolescence, 35, 903-911.

[28] Karalis, E., Ulander, V. M., Tapper, A. M., & Gissler, M. (2017). Decreasing mortality during pregnancy and for a year after while mortality after termination of pregnancy remains high: a population-based register study of pregnancy-associated deaths in Finland 2001–2012. BJOG: An International Journal of Obstetrics & Gynaecology, 124(7), 1115-1121.

vii) Fetal Mortality

42. While we are unable to clearly delineate the number of women who have had induced abortions in North Carolina, who have had complications from these induced abortions, or who may have died because of these complications, we are able to clearly identify the fetal mortality associated with induced abortion.

43. The second patient that obstetricians and gynecologists care for is our fetal patient (including embryos {conception to 8 weeks gestation} and fetuses {after 8 weeks until birth}). The purpose of an induced abortion is to produce a dead embryo or fetus. The intention of the procedure is for it to "not result in a live birth" as stated in the CDC's definition. With certainty, all 32,454 induced abortions in North Carolina reported in 2021 resulted in 32,454 fetal deaths. This violent approach forced on our second patient is most certainly not safe or essential health care for that pre-born child.

44. Maternal-fetal medicine is a sub-specialty in the field of Obstetrics and Gynecology that requires additional training to learn how to treat medical complications related to pregnancy. This sub-specialty is not just called maternal medicine, rather it is maternal-fetal medicine because there are two separate human beings that need exceptional medical care. The direct and intentional killing of a human being, whether born or pre-born is never the purpose of health care. Induced abortion is not health care nor is it essential or safe for our fetal patients.

45. Our fetal patients are defined by science as living humans at their earliest stage of human development. Embryology is the branch of biology that

studies the prenatal development of embryos and fetuses, as well as congenital disorders or birth defects. When I was in medical school years ago, the textbook for our class was Keith Moore's, "The Developing Human." That same textbook, updated over the years, remains widely used. The first page of Chapter 1, 10th edition, states: "human development is a continuous process that begins when an oocyte (ovum) from a female is fertilized by a sperm (spermatozoon) from a male. Cell division, cell migration, programmed cell death (apoptosis), differentiation, growth, and cell rearrangement transform the fertilized oocyte, a highly specialized, totipotent cell, a zygote, into a multicellular human being. Most changes occur during the embryonic and fetal periods; however, important changes occur during later periods of development: neonatal period (first 4 weeks), infancy (first year), childhood (2 years to puberty), and adolescence (11 to 19 years). Development does not stop at birth; other change, in addition to growth, occur after birth (e.g., development of teeth and female breasts)."[29] On the same page, the text summarizes the development periods, dividing human development into prenatal (before birth) and postnatal (after birth) periods. The prenatal period has two main periods: embryonic (through the first eight weeks after conception) and fetal (after eight weeks until birth). The postnatal period is divided into infancy, childhood, puberty, and adulthood.

46. Given the scientific fact that human development begins at conception, it is no surprise that so few obstetrician/gynecologists perform induced abortions. Desai et al surveyed obstetricians in private practice and found that only 7%

[29] Moore, K. (2016). The Developing Human: Clinically Orientated Embryology. Saunders.

performed an induced abortion in 2013-2014.[30] Grossman et al conducted a cross-sectional survey of a national sample of ACOG Fellows and Junior Fellows, and found that in 2016-2017, 72% reported having a patient in the prior year who needed or wanted an induced abortion, with only 23.8% reporting having provided an induced abortion. The most common reasons for not providing abortions included personal, religious, or moral beliefs against abortion (34%), practice setting restrictions against abortion provision (19%), office staff attitudes (16%), no perceived need (10%), and their patients had access to another provider or they referred out (8%).[31]

47. Obstetrician/gynecologists in North Carolina can provide safe and essential health care for both our maternal and fetal patients without providing induced abortion. Induced abortion is never safe for our fetal patients and complication rates associated with induced abortion are not fully known given the reporting structure that was in place prior to this law. The plaintiffs' claims that abortion is common, safe, and essential health care is false.

B. Increasing Safety for North Carolina Pregnant Women

48. The lack of safety of induced abortion for our fetal patients has been established. Induced abortions ends the life of all our fetal patients and is never safe. The safety of maternal patients who have induced abortions in North Carolina is unknown given the current reporting structures. What is known, however, is that

[30] Desai S, Jones RK, Castle K. Estimating abortion provision and abortion referrals among United States obstetrician-gynecologists in private practice. Contraception. 2018 Apr;97(4):297-302. doi: 10.1016/j.contraception.2017.11.004. Epub 2017 Nov 21. PMID: 29174883; PMCID.

[31] Grossman, D., Grindlay, K, Altshuler, A., & Schulkin, J et al(2019).Induced Abortion Provision Among a Sample of Obstetricians-Gynecologists. Obstetrics and Gynecology. 133(3):477-483.

North Carolina prioritizes safety for all North Carolina women who are pregnant and thus this law has two very important provisions that address maternal safety: 1) the requirement of induced abortions after 12 weeks gestation to occur in a hospital and 2) the requirement that an intrauterine pregnancy be documented prior to a chemical abortion.

i) Hospitalization Requirement

49. This law limits induced abortion after 12 weeks gestation except in complex cases. These complex cases include the exceptions for medical emergencies in which induced abortions can occur throughout the entirety of pregnancy, life limiting anomalies in which induced abortions can occur through 24 weeks, and rape/incest in which induced abortions can occur through 20 weeks.

50. Complex cases require complex care. Obstetricians and gynecologists complete four years of general ob/gyn training (residency) after medical school. There is an option to complete a fellowship in a variety of specialty areas, including complex family planning. This fellowship is an ACGME-accredited, two-year fellowship for obstetrics and gynecology (Ob-Gyn) residency graduates focused on subspecialist training in research, teaching, and clinical practice in complex abortion and contraception.[32]

51. It is rational for the state of North Carolina to want to protect pregnant women who are experiencing complex issues in their pregnancy to have care in a hospital instead of an outpatient setting. All the exceptions for the North Carolina

[32] https://societyfp.org/fellowship/.

law in which induced abortions after 12 weeks are available are complex and it is my opinion that they should take place in a hospital setting given the risks already discussed associated with induced abortions. Hospitals can handle major problems, including life-threatening hemorrhage, uterine perforation, damage to organs, and death that may occur during a surgical abortion or immediately afterwards. Hospitals have more resources to manage these complications, including blood banks for transfusions during emergencies, nurse anesthetists/anesthesiologists who can provide immediate intubation, code carts and code teams, as well as intensive care units. Performing induced abortions in hospitals after 12 weeks also prevents the need for transfer from an outpatient clinic to the nearest hospital facility should complications arise during the surgery, reducing the time for women to receive life-saving interventions.

52. Women in North Carolina in each of the exception categories have unique situations for which a hospital is best able to address. Women who are pregnant with a medical emergency clearly need to be in a hospital setting for the best chance for survival. Women in North Carolina who are victims of rape or incest have had horrific violence against them. Hospitals and emergency departments receive training to care for these women and ensure the forensic chain of evidence is followed.[33] Women in North Carolina who are pregnant with a fetus with a life-limiting condition are often in devastating situations in which both intense medical

[33] https://www.acep.org/patient-care/policy-statements/management-of-the-patient-with-the-complaint-of-sexual-assault.

and psychological support is essential. They may also need genetic testing, autopsy, and/or funeral arrangements which are available in a hospital setting.

ii) Documentation of Intrauterine Pregnancy Requirement

53. The plaintiffs' witnesses argue that documentation of an intrauterine pregnancy is not medically necessary prior to a chemical abortion. The use of chemical abortion not only jeopardizes the life of every preborn human being exposed to it but also represents one of the greatest threats to the health of women related to abortion. Chemical abortions have a 4x higher risk of complications than do surgical abortions in women who have been examined by a physician and the drugs are given through nine weeks gestation.[34]

54. The drugs used to induce an abortion are indicated for the first 10 weeks of pregnancy (current upper limit approved by FDA, though Dr. Farris states they knowingly use it through 11 weeks). After that, the risk of hemorrhaging increases and a surgical abortion is recommended. At 10 weeks gestation, 1 in 10 women will require a surgery to complete their abortion. At 13 weeks gestion, this complication increases to 1 in 2-3 women.[35] This a significant issue for many North Carolinian women that do not have immediate access to a hospital with 24/7 emergency surgical services available.

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[34] Niinimäki M, Pouta A, Bloigu A, Gissler M, Hemminki E, Suhonen S, Heikinheimo O. Immediate complications after medical compared with surgical termination of pregnancy. Obstet Gynecol. 2009 Oct;114(4):795-804. doi: 10.1097/AOG.0b013e3181b5ccf9. PMID: 19888037.

[35] Mentula MJ, Niinimäki M, Suhonen S, Hemminki E, Gissler M, Heikinheimo O. Immediate adverse events after second trimester medical termination of pregnancy: results of a nationwide registry study. Hum Reprod. 2011 Apr;26(4):927-32. doi: 10.1093/humrep/der016. Epub 2011Feb 11. PMID: 21317416.

55. The American College of Obstetricians and Gynecologists' Committee Opinion 700 was developed in coordination with the American Institute for Ultrasound in Medicine and Society for Maternal Fetal Medicine and states a proper estimated date of delivery (EDD) is paramount during pregnancy to improve outcomes and is a research and public health imperative. This Committee Opinion states that approximately one half of women accurately recall their last menstrual period (LMP) and thus ultrasound proves valuable to determine the actual estimated date of delivery (EDD).[36] Typically, between 5-6 weeks pregnancy a crown-rump length of the embryo can be performed by ultrasound to determine the gestational age and EDD.

56. Chemical abortion is not approved by the FDA after 10 weeks gestation or 70 days. It is essential that an accurate gestational age is documented by ultrasound prior to making decisions about the viability of a pregnancy.[37]

57. Without ultrasound to document an IUP, gestational age cannot be confirmed and women cannot possibly be adequately counseled on their risks if their gestational age is unknown. An abortion is a medical procedure, and an informed consent is required by law for all medical procedures.

58. An ultrasound is required to adequately rule out an ectopic pregnancy, one of the main contraindications to medication abortion. An ectopic pregnancy is defined as a pregnancy that occurs outside the uterine cavity. The most common site

[36] ACOG Committee Opinion 700. (2017). Methods of Estimating the Due Date: ACOG.

[37] ACOG Practice Bulletin 200. (2018). Early Pregnancy Loss: ACOG.

is the fallopian tube, which is why ectopic pregnancies are often called tubal pregnancies. Practice Bulletin 191 from the American College of Obstetricians and Gynecologists (ACOG), *Tubal Ectopic Pregnancy,* states that ectopic pregnancy accounts for approximately 2% of all pregnancies or 1 in 50 pregnancies.[38] An ectopic pregnancy cannot grow normally and most of these embryos die spontaneously. An ectopic pregnancy can be a life-threatening situation for the woman if the fallopian tube ruptures, causing internal bleeding.

59. The management of ectopic pregnancy remains the same pre and post *Roe*. An abortion is never used to treat an ectopic pregnancy. Treatment involves surgery or medication to terminate the pregnancy. These interventions are designed to save the pregnant woman's life but may have the unintended consequence of ending the embryo or fetus' life.

60. ACOG states in this same Practice Bulletin that "an untreated ectopic pregnancy is life-threatening; withholding or delaying treatment can lead to death." This death comes from internal bleeding, typically if the fallopian tube ruptures, and according to the CDC accounts for 2.7% of maternal deaths or deaths during pregnancy.[39] Determination of pregnancy location, intrauterine (in the uterus) versus ectopic (outside the uterus) requires an ultrasound as ACOG states in this same bulletin – "the minimum diagnostic evaluation of a suspected ectopic pregnancy is a transvaginal ultrasound evaluation and confirmation of pregnancy."[40]

[38] ACOG Practice Bulletin 191. (2018) Tubal Ectopic Pregnancy: ACOG.
[39] ACOG Practice Bulletin 191. (2018) Tubal Ectopic Pregnancy: ACOG.
[40] ACOG Practice Bulletin 191. (2018) Tubal Ectopic Pregnancy: ACOG.

61. Since the medications used to induce an abortion do not treat ectopic pregnancy, women who desire an induced abortion and receive abortion medications (mifepristone and misoprostol) without an ultrasound may result in delayed detection and treatment of an ectopic pregnancy, increasing the risk of greater internal bleeding and risk for death. The pregnant woman with an ectopic pregnancy may actually confuse the pain and bleeding of a ruptured ectopic pregnancy with the severe pain and bleeding experienced by chemical abortion drugs and thus delay potentially life-saving treatment leading to the catastrophic loss of women's lives in North Carolina.

62. This law requires that a physician document in the women's medical chart the existence of an intrauterine pregnancy prior to a chemical abortion. This is essential for the safety of the women of North Carolina. The plaintiff's witnesses discuss a protocol they use in their clinic in which they measure HCG levels at the same time of giving mifepristone. This approach is not standard of care and is dangerous. They falsely claim that HCG levels alone can be used to diagnose an ectopic. HCG levels must be interpreted in light of ultrasound findings and using HCG alone is not predictive of an ectopic pregnancy. ACOG's Practice Bulletin 191 states that an ectopic pregnancy is diagnosed with ultrasound.[41]

68. The state of North Carolina values each woman's life and it is rational then for the state to require a documented IUP prior to an induced abortion to determine gestational age to determine if a chemical abortion or surgical abortion is

[41] ACOG Practice Bulletin 191. (2018) Tubal Ectopic Pregnancy: ACOG.

provided and to rule out an ectopic pregnancy. This opinion is consistent both my profession opinion and with our states 2021 MMRC report that has as a goal to "make sure no woman dies as a result of pregnancy."[42]

I declare under penalty of perjury that the foregoing is true and correct. Executed on August 6, 2023.

Susan Bane, M.D., Ph.D.

Susan Bane, M.D., Ph.D.

[42] https://wicws.dph.ncdhhs.gov/docs/2014-16-MMRCReport_web.pdf.

Exhibit A

Susan Maxwell Bane, MD, PhD
drpinkglasses@gmail.com
4831 Wimbledon Court, Wilson, NC 27896
252-717-1891/252-399-6514

SKILLS SUMMARY

- **Physician.** Engaged listener with the ability to empathize with others, solve complex problems, and collaborate with other professionals in an environment that has multiple, simultaneous demands.
- **Teacher.** Award-winning teacher who understands and values the importance of incorporating liberal arts education within professional studies; adapts curriculum to optimize learning while meeting the needs of students.
- **Community leader.** Volunteer who identifies and meets the needs of the community through advocacy, education, and service on boards and organizations.
- **Effective communicator.** Experienced presenter and published author.
- **Administrator.** Analytical manager who identifies and solves problems by leading a team to collaborate and create solutions.
- **Consultant.** Professional development coaching for individuals, teams, and organizations, teaching the value of character strengths and emotional intelligence to create stronger teams. Innovator with success in recognizing strengths and challenges, listening to stakeholders, and leading organizations and groups forward .

EDUCATION AND TRAINING

Medical Training
Resident, Department of Obstetrics and Gynecology, East Carolina University School of Medicine, 1997- 2001
Doctor of Medicine, University of Illinois, 1997
Licensed to practice medicine in North Carolina
Graduate School
Doctor of Philosophy, Kinesiology, University of Illinois, 1995
Master of Science, Kinesiology, University of Illinois, 1989
Undergraduate School
Bachelor of Science, Chemistry, Atlantic Christian College/Barton College, 1987

PROFESSIONAL EXPERIENCE

Eastern North Carolina Pregnancy Centers

Pregnancy Centers with medical clinics within them provide exceptional medical care to women with unplanned pregnancies. They educate, support, and empower women facing unplanned pregnancies with compassionate and professional medical care.

Medical Director, Choices Women's Center 2013-present
Medical Director, Albemarle Pregnancy Resource Center and Clinic, 2023 – present
Medical Director, WaterLife Pregnancy Center, 2023-present

Administration

- Provides strategic direction and vision for Clinical operations.
- Works with the Board of Directors and Executive Director in setting clinic policy and ensuring full compliance in issues of ethics, legality, and compliance with all federal, state, and regulatory agencies including required reporting.

Clinical

- Serves as the Chief Medical Officer overseeing medical procedures within the clinic, including direct patient care.
- Keeps the Board of Directors and Executive Director informed of medical activities and development and prepares/submits recommendations for review and adoption.

Barton College, Wilson, NC

Barton College is a four-year, private liberal arts institution in eastern NC that believes in college on a first-name basis. Barton blends liberal arts and professional programs for 1100 traditional and adult students, has 18 Division II athletic teams, and shares a great relationship with the Wilson community.

Director, Barton College-Area L AHEC Partnership, 2021-2023
Associate Professor of Allied Health and Sport Science, 2010-2023
Director, Area L AHEC Scholars Program, 2017-2021
Dean, Graduate and Professional Studies, 2017-2019
Coordinator Health Promotions Major, 2013-2021
Women's Health Physician, 2010-2023
Director of the Honors Program, 2011-2017

TEACHING AND REASSIGNED TIME

Professor

- Teach a variety of interdisciplinary classes each semester including *Anatomy and Physiology, Anatomy and Physiology Lab, Autism: Brain Disorder or Disorder That Affects the Brain, Exercise Physiology, Exercise Prescription, Psychological and Social Aspects of Sport, Health and Wellness, Sport and Character Development,* and honors courses: *Nature of Inquiry* and *Mental Illness and the Movies*
- Helped develop professionalism curriculum for Department of Physical Education and Sports Studies, 2011-2012
- Supervisor for multiple students for Independent and Directed Study

Physician

- Women's Health Physician, Lee Student Health Center
- Medical Director, Choices Women's Center
- Leader in campus wellness initiatives for students, faculty, and staff

Director of Barton College-Area L AHEC Partnership

- Provide strategic planning for college, high school, and middle school health careers workforce development
- Oversee the AHEC Scholars Program by recruiting, teaching, and mentoring students for a Health Resources and Services Administration (HRSA) 5-year grant designed to provide students in health-related majors exposure to didactic and clinical opportunities
- Collaborate with faculty to develop and improve curriculum
- Network with local health care providers to connect students for clinical rotations

SCHOLARSHIP

Peer Reviewed Publications

Bane, S. (2015). Postpartum Exercise and Lactation. *Clinical Obstetrics and Gynecology*, 58(4), 885-892

Craven, K., Bane, S., & Kolasa, K. (2013). The Dance: Minimizing Weight Gain with Improved Blood Glucose Control. *Nutrition Today, 48,* 19-25

Peer Reviewed Presentations

Bane, S. *The Science of Decision Making: Implications for Pregnancy Centers,* Care Net National Conference, August 2022.

Bane, S., Christiansen, S., Thomas, A., & O'Connor, A. *Four Women and A Baby: A Medical-Legal Conversation about the Dobbs Opinion. Care Net National Conference,* August 2022.

Bane, S. & Venturella, G. *Covid and Clinicals: An Innovative Virtual Clinical Experience for NC AHEC Scholars,* National Area Health Center Education Organization, July 2021.

Bane, S. & Mihalko, S. *Functional Medicine: Training Physicians to Accomplish the SBM Mission,* Society of Behavioral Medicine National Meeting, April 2015

Stuart, L., Coen, J., Trump, C., & Bane, S. *Learning Behavior.* Workshop presented at the North Carolina Exceptional Children's Symposium, Pinehurst, NC, 2013.

Stuart, L., Trump, C., & Bane, S. *The impact of Verbal Behavior Implemented in the Classroom on the Families of Individuals with Autism,* North Carolina Autism Society, October 2013

Non-Peer Reviewed Publications

AHEC Scholars, Clinical Virtual Modules, 2021

Monthly Opinion Column, Wilson Daily Times, 2021-present

Bane, S. Youth Mission Trip Inspires Adult, *NC Catholic,* 2013, pp. 6-7

Non-Peer Reviewed Presentations

Bane. A Witness for our Patients: Our Response Post-Roe/Dobbs. SFL Health Professions Workshop, July 29. 2023.

Bane, S. *Women Deserve Exceptional Medical Care: Reviewing Key Components for our PRC Medical Clinics*. Lifelink State Medical Conference, Mar 4, 2023

Bane, S. and Renfrow, L. *Diversity and Inclusion in the Workplace: Strategies to Create a Thriving, Inclusive Culture at Area L AHEC,* 4-part lecture series, Spring 2021

Bane, S. & Greene, J. *Resiliency in the Workplace*, 4-part lecture series, Fall 2021.

Bane, S. *Does Compassion Matter: An Examination and Application of the Scientific Evidence,* Eastern AHEC Pharmacy Symposium, September 2020

Bane, S. *Character Strengths Matter:* Eastern AHEC Scholars Program, Greenville, NC: September 2019
Bane, S. *Emotional Intelligence Workshop*: Americorp Vistas, June 2019.
Bane, S. *Chronic Disease in the 21st Century: Using Functional Medicine to Create a Culture of Health*: Area L AHEC Pharmacy Continuing Education Presentation, 2018
Bane, S. *Parent Advocacy,* University of Georgia guest lecturer SPED 2000: Survey into Special Education, September 2016
Bane, S. *Healthy Selfishness*, Life Matters Retreat, April 2016
Bane, S. *Why Do You March?* St. Peters Catholic Church Life Teen, January 2016
Bane, S. *Welcome to Holland.* Farmville Middle School 4th Annual Exception Children's Awards Day, May 2015
Bane, S. *When Your Best Isn't Good Enough: Coping with Breastfeeding Failure,* Breastfeeding Symposium, Eastern Area AHEC Breastfeeding Symposium, August 2015
Bane, S. *Improving Sportsmanship,* CIC Athletic Conference Facilitator, August 2015
Bane, S. *Gratitude*. First Christian Church, Wilson, NC, November 2015
Bane, S. *Fear, Faith, and Freedom*, Life Matters Table Talk, February 2015
Bane, S. *Labor and Delivery: True Stories-Lessons Learned,* Breastfeeding Symposium, Eastern Area AHEC Breastfeeding Symposium, August 2014
Bane, S. EAHEC Department of Nursing Education Breastfeeding Symposium. *Minimizing Stress: Maximizing Success,* August 9, 2013
Craven, K., Bane, S., & Kolosa, K. *The Dance: Minimizing Weight Gain with Improved Blood Glucose Control.* Brody School of Medicine at East Carolina University Women's Health Conference, February 2012

Keynote Presentations
Bane, S. *Purpose, Passion, and Perinatology: Strategies to Move from Fatigue to Fulfillment.* Mountain AHEC Perinatal Substance Use Disorder Conference, November 2022.
Bane, S. *The Science of Decision Making: Implications for Pregnancy Centers*, Care Net National Conference, August 2022.
Bane, S. *Does Compassion Matter: An Examination and Application of the Scientific Evidence,* Eastern AHEC Continuing Education, September 2020
Walking the Tightrope: Breastfeeding and the Professional Woman, Eastern Area AHEC Breastfeeding Symposium, August 2014.
The Medical Side of Autism: Simple and Effective Ways You Can Help Your Child, Wilson County Schools, 2013.

Peer Review Editing
Peer Reviewer, Obstetrics & Gynecology, 2023-present.
Associate Editor, *Therapeutic Recreation Journal,* Spring 2014-2017.
Peer Reviewer, *Guidelines for Cardiac Rehabilitation and Secondary Prevention Programs, 5th ed.* by the American Association of Cardiovascular and Pulmonary Rehabilitation, 2013.
Peer Reviewer for Society of Behavioral Medicine Conference, 2017-2021

Grants
NCDHHS grant through Area L AHEC, Trauma-informed campus community, 2022-2023.
Interfaith Youth Corp, 2022-2023, $4000 to develop lectures on medicine and spirituality.

HRSA NC AHEC Grant, 2020-2021, $90,000 to develop Clinical Virtual Modules for AHEC Scholars across the State of North Carolina.
Healthcare Foundation of Wilson Grant: Wilson Fit: Using a Functional Medicine Approach to Prevent and Reduce Obesity - $426,000.
Healthcare Foundation of Wilson 2017-2018, $185,000
Faculty Development Grant, Spring 2017, $2500
Faculty Development Grant, Fall 2014, $1530
Faculty Development Grant, Summer 2014, $1530
Faculty Development Grant, Spring 2014, $3060
Faculty Development Grant, Fall 2013, $1530

Awards
BartonFIT/Barton College: Winner of the National Healthy Campus Week Physical Fitness Challenge: Healthier Campus Initiative, Fall 2019
Senior Leadership Academy Participant, 2015-2016
Faculty Club Advisor of the Year, 2016
Bulldog Club Award, 2014
Jefferson Pilot Faculty Member of the Year, 2012-2013

Professional Organizations
North Carolina Medical Society, 2023-present
American Association of Prolife Obstetricians and Gynecologists, 2020-present
American College of Obstetricians and Gynecologists, 1997 - 2021
Institute for Functional Medicine, 2013-2021

Board Membership
National Medical Advisory Board, Care Net, 2021-present
National Board, American Association of Prolife Obstetricians and Gynecologists, 2022-present

Certifications
Theology, Medicine, and Culture Certification, Duke Divinity School, 2022
Nationally Board-Certified Health and Wellness Coach, 2017
Institute for Functional Medicine Certified Practitioner, 2015
Emotional Intelligence Coach, 2016

SERVICE

Professional Development, 2017-present
- **Emotional Intelligence Training**
  - Students/Student Athletes
  - Athletic Coaches
- **Character Strengths Training**
  - Students/Student Athletes
  - Athletic Coaches
  - Senior Administration

Day of Scholarship Team Leader, 2013-2018
- Recruited faculty and students to serve on team
- Led planning and event management for the symposium
- Helped restructure the application process for participants
- Organized Scholars Symposium Archival Research presentation for Retired Faculty Society

Barton FIT, 2016-2021
- Successfully wrote and received a grant to expand employee wellness programming
- Implemented a functional medicine intervention for employees who were overweight or obese
- Brought a weekly farmers market to campus
- Organized monthly lunch and learn sessions
- Enhanced the human performance lab with equipment for fitness testing
- Provided opportunities for allied health majors to participate in "hands-on trainaing"
- Striving to make Barton a culture of health and one in which the health and well-being of employees is valued

Guest Speaker Representing Barton
Wilson Rotary Club, Spring 2023
Wilson Noon Kiwanis Club, June 2018
Greenville Rotary Club, January 2018
Wilson Optimist Club, Summer 2017
Honors Program presentation to Board of Trustees, Spring and Fall 2013
Barton College Scholarship Luncheon, April 2013

Keynote Speaker
Alpha Chi Induction, March 2016
Women in Sports Day, February 2014
Administrative Assistant Luncheon, April 2012
Alpha Chi Honor Society Induction, March 2012

Guest Speaker at Barton
Bane, S. *Roe V Wade Overturned: How Does the Dobbs Supreme Court Decision Impact You?* Barton College Intellectual Bluepirnt Event, April 2023.
Bane, S. *Does Compassion Matter: An Examination and Application of the Scientific Evidence,* Junior Nursing Class, November, 2020.
Character Strengths Matter: Barton College Senior Leadership Team, Monthly, 2019-2020
A Baseball, A Breath, and A Life: Brandon Warren's Story, August 2019
Gratitude, Student Affairs, November 2017
What Kind of Life is Truly Worth Living, Vocations Avila Retreat, February, 2017
The Legacy of the Barton Women's Tennis Team, Women's Tennis Team, April 2017
Healthy Choices, FYS Class, February, 2016
Research through the Barton Archives, Rare Book Symposium, Barton College, October 2015
Abortion, FYS Class, October 2015
Faculty Forum: presented details of the new Health Promotions Major, February 2014

Panelist, discussed cervical cancer in the context of the book, *The Immortal Life of Henrietta Lacks,* 2012
First Year Seminar workshop, discussed Health Promotions Major, Summer 2014
Important Health Issues I Know Now, But Wish I Had Known As a College Student, Residence Hall Association, March 2014
Panelist for an STD educational program for students on campus, March 2014
My Story, FYS class, November 2013
Shine on, Teach On: *Stress Management for Student Teachers*, September 2012
Healthy Choices, FYS, two classes, Fall 2011
What Do You Believe and Why? Fellowship of Christian Athletes, October 2012
Introduction to Exceptional Children's class*,* April 2012

Sport Psychology, Professional Development Consultant, Barton Athletic Department
Men's Volleyball, Spring 2022
Women's Softball, Fall 2013
Women's Soccer Team, Spring 2013
Men's Golf Team, Fall 2012
Men's and Women's Tennis Teams, Fall 2012

Barton Service Positions
Faculty Athletic Mentor, Women's Lacrosse, 2022-2023
Faculty Athletic Mentor, Men's Volleyball, Spring 2022
Faculty Representative to the Board of Trustees 2016-2018
Moderator, Faculty Forum, 2014-2018
Advisor, Barton Autism Society
Advisor, Barton Catholic Campus Student Ministry
CARE team member
Strategic Planning Committee 2015-2016, 2019-2020
- Chair of Subcommittee on developing motivation and resilience in students
- Strategy Champion (Emotional Intelligence)
    - Helped organize training for 10 employees to become certified in administering and debriefing the EQ-i2
    - Collaborated with FYS team to incorporate emotional intelligence into FYS course

Wilson Community Service Projects
- Help organize annual Autism Awareness Day
    - Open house for middle and high school students with autism, 2012-present
    - Light It Blue Party for Wilson County Schools students with special needs 2013
- Coordinated presentation of Personal Fitness Badges, Boy Scouts of America, 2013-present
- Coordinated and planned "Dig Pink" event with Barton College Women's volleyball team and the Pink Ladies of Wilson Medical Hospital Foundation

Community Service Positions
Medical Director, Wilson Pregnancy Center, 2014-present
Committee Member, Pre-born to End-of-Life Advisory Committee, Diocese of Raleigh, 2013-2020

Community Service Presentations

Preparing for a Post-Roe Albemarle Pregnancy Center: Albemarle Pregnancy Center, June 2022
Preparing for a Post-Roe Wilson: St. Therese Catholic Church, May 2022
Preparing for a Post-Roe Wilson: Choice's Women's Center, March 2022
Fetal Development: Wilson Pregnancy Center, October 2019, October 2020
Character Strengths Matter: Department of Social Services, December 2019.
Character Strengths Matter: GIG360, December 2019
Why March? St. Therese Confirmation Class, January 2018
Mind, Body, Medicine: Wilson YMCA, January 2018
Labor and Delivery: True Stories, Lessons Learned. Eastern North Carolina Women in Business Conference, Greenville, NC, March 2014.
The Beginning of Life: True Stories: Lessons Learned, The Diocese of Raleigh Catholic Convention, October 2013.
Mental Muscle, Community Christian School Girls' Soccer Team, May 2013.
Smart, Educated, and Love Jesus? St. Peters Catholic Church Life Teen, January 2013.
Shine On: Keeping Your Light and Life Bright. Wilson Community Church MOPS, Wilson, NC, January 2013.
It Is the Most Wonderful Time of the Year. St. James United Methodist Church Women's Conference, Greenville, NC, 2012, 2013.
Labor and Delivery: The Value of Life. St. Peters Catholic Church, October 2012.
Keeping Your Light Shining. First Baptist Church Women's Conference, Farmville, NC, October 2012.
Staying Healthy in the Midst of the Rat Race. Second Annual Eastern North Carolina Women in Business Conference, March 2011.

Committees

Wilson Forward Wellness Collaboration, 2018-present
Health Care Advancement Collaborative, Eastern North Carolina, 2022-present
Faculty Representative to the Board of Trustees 2016-2017
Campus Welfare Committee 2016-2020
Faculty Representative to the Barton Alumni Board 2015-2016
Institutional Review Board, 2014-2015
Research Task Force, 2013-2015
Honors Council, 2013-2018
Compliance Campus Regulatory Compliance Task Force, 2011-2014
Academic Quality, 2011-2013
Pool Working Group, 2012

Physicians East, PA, Greenville, NC

Multi-specialty medical practice consisting of a team of healthcare professionals committed to helping individuals improve and maintain their health by providing compassionate, state-of-the-art care.

Partner and Shareholder, 2004-2010
Obstetrician/Gynecologist, 2001-2010
Clinical Professor, 2001-2010

Adjunct Professor, 2001-2010

ADMINISTRATIVE

Partner and Shareholder
Greenville Obstetrics and Gynecology, A Division of Physician's East, August 2004-May 2010

- Managed $5 million practice with 50 employees and 2500 patients
- Directed and coordinated activities of nurses, assistants, therapists, ultrasonographers, and business and other medical staff
- Oversaw resource allocation of budget with partners
- Marketed practice through branding and strategic advertising and community relations
- Supervised four midwives in the practice, including managing personnel concerns
- Played an active role in human resources, particularly hiring new employees and physicians
- Led positive workplace culture initiatives, such as wellness programming, incentives, and staff social activities
- Developed FitEast, a Comprehensive Wellness Program for 400 employees of Physicians East, PA, 2005

Legal Consultant
For medical malpractice and legal claims, 2006-present
For Catholic Diocese of Raleigh on legal documentation for end of life issues, 2013-present

CLINICAL

Obstetrician/Gynecologist
Greenville Obstetrics and Gynecology, A Division of Physician's East, August 2001-May 2010

- Collected, recorded, and maintained patient information, such as medical histories, reports, and examination results
- Prescribed or administered therapy, medication, and other specialized medical care to treat or prevent illness, disease, or injury
- Cared for and treated women during prenatal, intrapartum, and postnatal periods
- Performed surgical procedures
- Analyzed records, reports, test results, or examination information to diagnose medical condition of patient
- Explained procedures and discussed test results or prescribed treatments with patients
- Monitored patients' conditions and progress and reevaluated treatments as necessary
- Referred patients to medical specialist or other practitioner when necessary
- Consulted with or provided consulting services to other physicians
- Provided opportunities for numerous high school and pre-med students to shadow

Clinical Professor
Department of Obstetrics and Gynecology, East Carolina University, August 2001-May 2010

Taught the following:
- Third- and fourth-year ECU medical school students in office and hospital setting

- First- and second-year UNC-Chapel Hill medical school students in the office and hospital setting
- *Residency 101,* elective course for fourth-year medical students to better prepare them for residency, 2003-2006

Co-Coordinator, Resident Journal Club, Department of OB/GYN, 2004-2010

Adjunct Professor
Department of Exercise and Sports Science, East Carolina University, August 1999-August 2011

- Guest lecturer in ECU Department of Exercise and Sports Science
- Consulted with department on student master's thesis research

Author
Women's Health Column, HER Magazine, 2007-2012

Professional Awards
Attending of the Year, Clinical Faculty, Presented by the Obstetrics and Gynecology Residents for Outstanding Teaching, 2003, 2005, 2006, 2007
Outstanding Community Physician Award, presented by Brody School of Medicine Class for Outstanding Teaching 2006, 2007, 2008, 2009

Professional Organizations
Society of Behavioral Medicine
American College of Sports Medicine
North Carolina Society of Obstetrics and Gynecology
Institutional Function
American Congress of Obstetrics and Gynecology

PRESENTATIONS

Non-Peer Reviewed Presentations
Heal Thyself: Finding Life Balance. Regional Perinatal Symposium, 2010.
Exercise and Pregnancy. Brody School of Medicine Pediatric Conference, 2008.
Sexual Dysfunction: She Loves Me, She Loves Me Not. Brody School of Medicine Family Practice Women's Health Conference, 2007.
Fit for Life. Brody School of Medicine Family Practice Women's Health Conference, 2007.
The Risk and Management of a Few Extra Pounds. Women's Health Conference, Family Practice Department, East Carolina University School of Medicine, February 2003.
The Risk and Management of a Few Extra Pounds. Seaboard Medical Society, June 2003.

SERVICE

Community Service Positions
Chairman of the Board, TRAC Educational Services, Winterville, NC, 2007-2010

Alumna of Barton College

Keynote Speaker, Barton Fall Convocation, 2009

Community Service Positions
Volunteer Softball Coach, Pitt County Girls' Softball League, 2006
- Coached softball team for girls ages 5-12
- Identified need for sportsmanship program and created The Sportsmanship Zone
- Developed comprehensive training program and presented strategic plan to board of directors for approval
- Raised $28,000 to fund program
- Created and executed branding campaign to increase public awareness of the program and educate the community about sportsmanship
- Trained coaches, parents, and players

Volunteer Softball Coach
- St. Peter's Catholic School, 2008
- Farmville Central High School, Junior Varsity team, Farmville, NC, 2011

Team Leader, St. Peter's Catholic Church Mission Trip, 2011, 2012, 2014

Service Awards
Barton College Alumni Achievement Award, 2010
Pitt County Girls Softball League Recognition Award, 2010

Community Service Presentations
- Coordinator/Lecturer: *It Is Good to Be a Woman* community seminar sponsored by Greenville OB/GYN, 2006.
- Coordinator/Lecturer: *Wednesday Women's Wellness* community series sponsored by Greenville OB/GYN, 2001-2004.

Barton College Community Service
Academic Quality Committee, Barton College, Wilson, NC, 2010
Board of Advisors, Barton College, Wilson, NC, 2009-2010

Committees
Block Committee, SurgiCenter, Greenville, NC, 2005-2010
Board of Directors, Fellowship of Christian Athletes, Greenville, NC, 2002-2006
Labor and Delivery Advisory Board, Vidant Medical Center, Greenville, NC, 2003
Post-Partum Depression Committee, Vidant Medical Center, Greenville, NC, 2002

Department of Obstetrics and Gynecology, East Carolina University School of Medicine

ECU School of Medicine, located in Greenville, NC, serves the rural population of Eastern NC. The four-year residency program includes additional training in medicine and surgery, research, and teaching.

OB/GYN Resident, 1997- 2001
Performed the duties of a licensed OB/GYN under the supervision of attending physician

SCHOLARSHIP

Peer Reviewed Publications

Bane, S.M. and McAuley, E. (1998) Body Image and Physical Activities. Measurement Issues. In J. Duda (Ed.), *Advances in Sport and Exercise Psychology Measurement* (p. 311-324). Fitness Information Technology: Morgantown, WV.

Katea, J.A., McAuley, E., Mihalko, S.L., and Bane, S.M. (1998) Mirror, Mirror on the Wall: Exercise Environmental Influences on Self Efficacy. *Journal of Social Behavior and Personality,* 13,219-232.

McAuley, E., Mihalko, S.L., and Bane, S.M. (1997). Exercise and Self-Esteem in Middle Aged Adults: Multidimensional Relationships and Physical Fitness and Self-Efficacy Influences. *Journal of Behavior Medicine,* 20, 67-83.

Martin, K.A., Rejeski, W.J., Leary, M.R., McAuley, and Bane, S.M. (1997). Is the Social Physique Anxiety Scale Really Multidimensional: Conceptual and Statistical Argument for a Unidimensional Model? *Journal of Sport and Exercise Psychology,* 19, 359-369.

Peer Reviewed Presentations

Bane, S.M. *Fever of Unknown Origin: Stump the Professor.* American College of Obstetrics and Gynecology, District IV Meeting, October 2000.

Bane, S.M. *Writing an Exercise Prescription.* Seaboard Medical Association Meeting, June 1999.

Bane, S.M. and McAuley, E. *Comparison of Body Image in Caucasian and African American Females: Implications for Practice.* American College of Obstetrics and Gynecology, District IV Meeting, October 1999.

Bane, S.M., McAuley, E., & Shackelford, P. *Exercise, Weight and Body Image in College Females: Putting Theory into Clinical Practice.* Paper presented at the American College of Obstetrics and Gynecology, District IV Meeting, October 1998.

Awards

Outstanding Teaching Resident, East Carolina University, Presented by the Graduating Medical School Class of 2001

Second Year Resident of the Year, Presented by the 1999 Intern Class in Obstetrics and Gynecology Residency

Outstanding Junior Fellow Presentation, ACOG District IV Meeting, 2nd place, October 1999

Outstanding Junior Fellow Presentation, ACOG District IV Meeting, 2nd place, October 1999

Athletic Hall of Fame, Barton College, 1998

SERVICE

Community Service Presentations

Exercise and Pregnancy. East Carolina Physical Therapy Graduation Seminar, May 2001.

Writing an Exercise Prescription. North Carolina Ob/Gyn Society Annual Meeting, April, 2001.

Exercise and Pregnancy. Department of Obstetrics and Gynecology Grand Rounds, September, 2000.

Enjoying a Healthy Body Image. Seaboard Medical Association, June 2000.

Exercise for a Lifetime. Seaboard Medical Association, June 2000.

Exercise and Pregnancy. Pulse Athletic Club, 2000.

Fresh Start 2000: Exercise Guidelines for Health and Fitness. Pulse Athletic Club, January 2000.

Exercise, Weight and Body Image. Women's Health Conference, AHEC, October 1999.
The Ten Commandments for Life. Currituck County High School Graduation, 1999.
Writing an Exercise Prescription: Putting Research into Clinical Practice. Department of Obstetrics and Gynecology Grand Rounds, October 1998.
Enjoying a Healthy Body Image. Pulse Athletic Club, Greenville, NC, September 1998.

University of Illinois, Urbana, IL

The medical school at the University of Illinois offers a four-year program leading to the MD degree at four different sites in Illinois. The University of Illinois graduate program provides opportunities for students to research, learn, and teach while earning a graduate degree.

Medical School Student, 1991-1997
Graduate School Student, 1987-1995
Graduate School Teaching Assistant, 1987-1995
Research Assistant, Department of Special Education, 1987- 1989
Research Assistant, Department of Kinesiology, 1994-1997
Men's Tennis Coach, Parkland Junior College, 1988-1990

Peer Reviewed Publications

McAuley, E., Mihalko, S.L., and Bane, S.M. (1996). Acute Exercise and Anxiety Reduction: Does the Exercise Environment Matter? *Journal of Sport and Exercise Psychology,* 18, 408-419.
Mihalko, S.L., McAuley, E. and Bane, S.M. (1996). Self-efficacy and Affective Response to Acute Exercise in Aged Adults. *Journal of Social Behavior and Personality,* 11, 375-385.
Bane, S.M. and McAuley, E. (1995). Reducing Physique Anxiety in College Females. *Medicine and Science in Sports and Exercise.* Vol 27(5), Supplement.
McAuley, E., Bane, S.M. & Bozoian, S.L. (1995). Exercise in Middle-Aged Adults: Self-Efficacy and Self-Presentational Strategies. *Preventive Medicine,* 24, 319-328.
McAuley, E., Bane, S.M., Rudolph, D. & Lox, C. (1995). Physique Anxiety and Exercise in Middle-Aged Adults. *Journal of Gerontology: Psychological Sciences.* 50B, 229-235.
Kennedy, C., Reis, J., Bane, S.M. and Stang, J. (1995). A Comparison of Body Image in Exercising and Nonexercising College Students. *Wellness Perspectives,* 11(3).
Bane, S.M. and McAuley, E. (1994). Physical Attributes, Self-Perceptions and Social Physique Anxiety in College Female: A Self-Presentational Perspective. *Medicine and Science in Sports and Exercise, Vol. 26:5,* Supplement.
Halle, J., Gabler-Halle, P., McKee, M., Bane, S.M. & Boyer, T. (1991). *Enhancing the Aerobic Fitness of Individuals with Moderate and Severe Disabilities: A Peer Mediated Aerobic Conditioning Program.* Champaign, IL: Sagamore Publishing.
Bane, S.M., dos Anjos, L.A., Boileau, R.A., Misner, J.E. & Soares, J. (1989). Comparison of the 40 second run with traditional aerobic field tests and the Wingate Test. Anais do *IX Congress Brasileiro de Medicine Esportiva,* Sao Paulo, Brazil, p. 10.

Peer Reviewed Presentations

Bane, S.M. & McAuley, E. *The Role of Efficacy Cognitions in Reducing Physique Anxiety in College Females.* American College of Sports Medicine Conference, June 1996.
McAuley, E. & Bane, S.M. *Exercise and Body Image in College Females.* American College of Sports Medicine Conference, June 1996.

Bane, S.M. & McAuley, E. *Exercise and Cognitive Behavioral Effects on Body Image.* Society of Behavioral Medicine Conference, March 1996.

Bane, S.M. & McAuley, E. *Body Image in African American and Caucasian College Females: A Self-Presentational Perspective.* Society of Behavioral Medicine Conference, March 1996.

McAuley, E., Bozoian, S. & Bane, S. *Exercise and Self-Esteem in Middle-Aged Adults.* Society of Behavioral Medicine Conference, March, 1995.

Bane, S. & McAuley, E. *Exercise, Efficacy and Physique Anxiety in College Females.* Society of Behavioral Medicine Conference, March 1995.

Bane, S. & McAuley, E. *Reducing Social Physique Anxiety and Enhancing Body Image in College Females: A Self-Presentational Perspective.* American College of Sports Medicine, June 1995.

McAuley, E., Bane, S & Bozoian, S.L. *Self-Efficacy, Exercise and Physique Anxiety in Older Adults.* American College of Sports Medicine, June 1995.

Bozoian, S.L., McAuley, E. & Bane, S. *Self-Esteem and Exercise Relations in Middle-Aged Adults.* American College of Sports Medicine, June 1995.

Bane, S. & McAuley, E.: *Physical Attributes, Self-Perceptions and Social Physique Anxiety in College Females: A Self-Presentational Perspective*. Paper presented at the Medical Scholars Research Symposium, February 1994.

Bane, S. & McAuley, E.: *Physical Attributes, Self-Perceptions and Social Physique Anxiety in College Females: A Self-Presentational Perspective*. Paper presented at the American College of Sports Medicine, June 6, 1994.

Graduate School Awards

Outstanding Teaching Assistant, University of Illinois, 1989-1994

Outstanding Graduate Student, Department of Kinesiology, University of Illinois, 1995

Phi Kappa Phi Honor Society 1995

Avery Brundage Scholarship, 1990, 1991

Grants and Fundraising

Dissertation Grant, Department of Kinesiology, University of Illinois Graduate School, 1995, $650

Laura Huelster Award, Department of Kinesiology, University of Illinois Graduate School, 1995, $1200

Dissertation Grant, American College of Sports Medicine Foundation, 1995, $2255

American College of Sports Medicine Graduate Student Research Grant, 1994

Community Service Presentations: Medical School

Writing an Exercise Prescription. St. Francis Hospital, Peoria, Illinois 1996.

Internal Medicine Resident's Conference, September 1996.

Enjoying a Healthy Body Image. St. Joseph's Hospital, Bloomington, Illinois, Community Lecture Series, June 1996.

What is a Healthy Body Image? Morton High School Women's Athletic Teams, Morton, Illinois, October 1995.

Enjoying a Healthy Body Image. St. Joseph's Hospital, Bloomington, Illinois Center for Healthy Living, October 1995.

Enjoying a Healthy Body Image. St. Joseph's Hospital, Bloomington, Illinois Center for Healthy Living, May 1995.

Community Service Presentations: Graduate School

Developing a Healthy Body Image. Parkland College Staff Development, October 1994.
Developing a Healthy Body Image. Twin City Fitness Associates, July 1994.
Exercise and Pregnancy. McKinley Health Center, Urbana, IL, June 1994.
Exercise and Weight Control. International Student Symposium, University of IL, Urbana, IL, April 1994.
Exercise and Pregnancy. McKinley Health Center, Urbana, IL, February 1994.
Exercise and Pregnancy. McKinley Health Center, Urbana, IL, October 1993.
Body Image. Northwest Naval Base, June 1993.
Body Consciousness. Champaign Junior Women's League, May 1993.
Fitness Through Daily Activity. North West Naval Base, April 1993.
Exercise and Pregnancy. McKinley Health Center, Urbana, IL, March 1993.
Mirror Mirror in My Mind. Northwest Naval Base, January 1993.
Exercise and Pregnancy. McKinley Health Center, Urbana, IL, December 1992.

Undergraduate Awards at Atlantic Christian College/Barton College

Summa Cum Laude, 1987
Faculty Cup for Most Outstanding Senior, 1987
Academic All-American (tennis), 1986, 1987
Honorable Mention All-American (tennis), 1987
All-District (tennis), 1985, 1986, 1987
All-Conference (tennis), 1985, 1986, 1987
Most Valuable Player (tennis), 1987
Edward E. Cloyd Top Academic Athlete Award, 1987
Female Athlete of the Year, 1987
Homecoming Queen, 1984